STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495196	A. BUILDING **01, 02** B. WING _____	R **07/27/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN CARE OF ALTAVISTA	**1317 LOLA AVE** **ALTAVISTA, VA 24517**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS Construction Type: III (211) Description of Structure: The facility is a single story building with wood T-111 type siding and a concrete floor. Sprinkler Status: The facility is fully sprinklered with NFPA #13 systems, supplied by municipal water. An unannounced revisit to the Life Safety Code survey conducted on 04/21/16 was conducted on 07/27/16 , in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the LSC Existing 2000 regulations. The facility was in compliance with the Requirements for Participation Medicare and Medicaid. Corrected deficiencies are identified on the CMS-2567B. Construction Type: V (111) Description of Structure: The facility is a single story addition to the main building of wood frame construction and a concrete floor. Sprinkler Status: The facility is fully sprinklered with NFPA #13 systems, supplied by municipal water. An unannounced revisit to the Life Safety Code survey conducted on 4/21/06 was conducted on 07/27/16 , in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for	{K 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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AUTUMN CARE OF ALTAVISTA	**1317 LOLA AVE** **ALTAVISTA, VA 24517**

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{K 000}	Continued From page 1 compliance using the LSC Existing 2000 regulations. The facility was in compliance with the Requirements for Participation Medicare and Medicaid. Corrected deficiencies are identified on the CMS-2567B.	{K 000}		